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Health Locus Of Control And Spiritual Well-Being Of Participants In Narcotics Anonymous

Melinda Hamlin
Mississippi University for Women

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Melinda Hamlin

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ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

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by

Melinda Hamlin

Associate Professor of Nursing
Director of Thesis

Professor of Nursing
Member of Committee

Assistant Professor of Nursing
Member of Committee

Director of the Graduate School

Dedication

This thesis is dedicated to my mother, Dorris Lee Rutledge, who went to be with the Lord in November 1986. It was her undying love and spirit that gave me the will and determination to return to school, first in 1987 for my BSN and then in 1989 for my MSN. Mom, I wish you were here--but somehow I know you know.

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To my precious Mallory, you truly are the sunshine of my life. Thanks for all the stolen moments and "helping" mom do her "study." Now--my time is yours!

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As I complete the pages of this thesis, I must thank the one who has given me inspiration and hope during the last year--my grandmother. My only hope is that I will inherit her love of life and energy. Nanny, thanks for always being there!

Abstract

The purpose of this descriptive correlational study was to determine the relationship between health locus of control and spiritual well-being of participants in Narcotics Anonymous. Research questions to be answered included:

1. What is the health locus of control of participants in Narcotics Anonymous?

2. What are the level and dimension of spiritual well-being of participants in Narcotics Anonymous?

3. What is the relationship between health locus of control and spiritual well-being of participants in Narcotics Anonymous?

4. What are the relationships among age, months attending Narcotics Anonymous, years addicted and health locus of control and level of spiritual well-being of participants in Narcotics Anonymous?

5. Two open-opened questions about the participant's recovery from drug addiction.

Erickson, Tomlin, and Swain's (1983) Modeling and Role-Modeling provided the conceptual framework. The sample was composed of 20 men and women who were participants in Narcotics Anonymous and 18 years and older. Data were

collected by a gatekeeper to maintain anonymity. Three questionnaires were used: Multidimensional Health Locus of Control Scale, Spiritual Well-Being Scale, and a Demographic Data Sheet. Data were analyzed using descriptive statistics, the Pearson Product Moment Correlation procedure, and content analysis. The health locus of control for the participants in this study was determined to be internal. The level and dimension of spiritual well-being of the recovering drug addicts were found to be unimpaired. A significant negative relationship was discovered between MHLC and SWB, RWB, and EWB. No significant relationships were found among age, months attending Narcotics Anonymous, years addicted and health locus of control and level of spiritual well-being of participants. Three reasons were described for seeking help: personal, legal, and family. Eighty percent of the participants listed Narcotics Anonymous as the major influence in their recovery. This study suggests that fostering internal self-strengths, such as health locus of control and spiritual well-being, may promote more effective treatment for the recovering drug addict. It further suggests that Narcotics Anonymous is an important external coping resource. Further research is indicated. Recommendations from this study include replication using a larger sample size and comparing recovering drug addicts who attend Narcotics Anonymous and recovering drug addicts who

do not. Other recommendations include an exploratory study to identify successful treatment modalities other than Narcotics Anonymous and a longitudinal study through recovery and over time in Narcotics Anonymous.

Table of Contents

List of Tables

Chapter I

The Research Problem

It is estimated that each day 5,000 Americans experimentally use cocaine for the first time, and these 5,000 join the more than 20 million Americans who have already used the drug. According to studies, 4 to 6 million persons are compulsive users of cocaine (Consumers' Research, 1988). Many cocaine users have been heavily involved with other drugs, and virtually all have used marijuana before using cocaine. There is clear evidence of a steady increase in the number of recognized drug addicts, and the annual increase has accelerated since 1977 (Spear, 1982). This startling data over the years formed the basis for President Bush declaring war on drugs in 1989.

Successful recovery rates for recovering drug addicts are low. Many drug addicts seek help each year from various treatment centers and self-help groups such as Narcotics Anonymous. The alternatives for a drug addict who can no longer function as a human being are few--jail, institution, death, or finding a new way to live (Narcotics Anonymous, 1976). Narcotics Anonymous offers a 12-step program that one can follow in daily life to overcome addiction and

remain on the road to recovery. Many recovering addicts find solace and success in this program.

Spiritual well-being and health locus of control are personal self-strength resources available to the recovering drug addict, and possibly predictors of that recovery. Spiritual factors are considered important to recovery and are spoken to in numerous steps throughout the 12-step program of Narcotics Anonymous, e.g., "We came to believe that a Power greater than ourselves could restore us to sanity" (Narcotics Anonymous, 1983). Research suggests that spiritual well-being is an invaluable coping resource that influences psychological well-being and is positively related to coping abilities in chronic illness (Carson, Soeken, & Grimm, 1988). No research has been done to determine the spiritual well-being of recovering drug addicts.

It is theorized that people with addictive behaviors who are characterized as internals by the Multidimensional Health Locus of Control Scale (MHLC) recover easier and are more likely to remain recovered (Chavez & Michaels, 1980; Huckstadt, 1987). The health locus of control of people with other addictive behavior such as overeating, drinking, and smoking have been studied (Chavez & Michaels, 1980; Huckstadt, 1987; Platt, 1969). Yet, no research has been conducted related to the health locus of control of the recovering drug addict.

Purpose of the Study

The purpose of this study was to determine the relationships between health locus of control and level of spiritual well-being of participants of Narcotics Anonymous. The level and dimensions of spiritual well-being and the health locus of control for participants in this study were determined. Relationships among demographic variables, health locus of control, and spiritual well-being were explored.

Background and Significance of the Study

There is little research on drug addiction specific to the recovering drug addict. Drug abuse is plaguing our nation. Cocaine use has become one of the major social and health problems in this country, according to the National Institute on Drug Abuse (Consumers' Research, 1988). Drug use has permeated almost all social and professional levels of society, including the health professions. Rehabilitation success for the recovering drug addict is poor. Information is needed to assist health professionals in better understanding the recovering drug addict's world in order to develop more effective treatment programs.

This study adds knowledge of recovering drug addicts and their motivation for continued recovery. It will add insight into the lifelong process of recovery. This study explored spiritual well-being and health locus of control as self-strength resources for recovering drug addicts seeking

treatment through Narcotics Anonymous. The results of this study can be used to develop educational programs for nurses about the recovery process in drug addiction. The results may add insight into the most effective mode of treatment for the recovering drug addict.

Statement of the Problem

This study addressed the question: What is the relationship between health locus of control and level of spiritual well-being of participants in Narcotics Anonymous?

Research Questions

The research questions posed by this endeavor were

1. What is the health locus of control of participants in Narcotics Anonymous?
2. What are the level and dimensions of spiritual well-being of participants in Narcotics Anonymous?
3. What is the relationship between health locus of control and spiritual well-being of participants in Narcotics Anonymous?
4. What are the relationships between age, months attending Narcotics Anonymous, years addicted to drugs and locus of control and level of spiritual well-being of participants in Narcotics Anonymous?
5. Two open-ended questions: What prompted you to come to Narcotics Anonymous? What or who has been the major influence in your recovery from addiction? Why?

Conceptual Framework

The theoretical framework for this study was Modeling and Role-Modeling (Erickson, Tomlin, & Swain, 1983). The theory uses psychological, cognitive, and biological theories as the theoretical base for the observations the theorists make regarding similarities and differences among individuals. The work of Abraham Maslow, Erik Erickson, Milton H. Erickson, Jean Piaget, George Engel, and Hans Selye are salient in the development of this theory (Stein, 1989).

Modeling is defined as the process by which the nurse seeks to understand the client's unique model of the world (Erickson et al., 1983). Because each individual has a personal model of the world, people with nursing needs may not be helped in standardized ways. Understanding the recovering drug addict's model of his world will assist the health professional in delivering timely and individual intervention. Role-modeling is the process by which the nurse facilitates clients to attain, maintain, or promote health through purposeful interventions (Erickson et al., 1983).

Modeling and Role-Modeling addresses the complex interrelatedness of cognitive subsystems and the individual's ability to cope effectively with stressors to maintain a state of holistic health and well-being. The construct of health is viewed as a dynamic state and an

outcome of continuous adapting to stressors. When one responds to a stressor in a positive, growth-producing manner, a state of adaptive equilibrium is reached. The ability to cope with a stressor is determined by several factors: meaning given the stressor, available coping resources, and adaptive energy available to mobilize coping resources (Stein, 1989). Coping resources include the biophysical, psychosocial, and spiritual assets of the individual. The availability of adaptive energy to mobilize coping resources is directly related to how well the person's basic needs have been met (Erickson et al., 1983).

Adaptive energy had been classified into three adaptive potential states identified in the Adaptive Potential Assessment Model (APAM): arousal, equilibrium, and impoverishment. A dynamic relationship exists between these adaptive states with each representing different adaptive potential for mobilizing coping resources (Erickson et al., 1983).

The arousal state of the APAM is a stress state in which an individual responds to a stimulus or stressor such as drug addiction. The equilibrium state of the APAM is a nonstress state in which the individual has good adaptive potential for mobilizing internal self-strengths such as spiritual well-being and health locus of control. Although a steady state, the nature of equilibrium may be either adaptive or maladaptive. Adaptive equilibrium exists when

the individual uses coping resources in a growth and health-directed manner that leaves no subsystem (biophysical, psychosocial, or spiritual) at risk for depletion of energy. Adaptive equilibrium is a desired adaptive potential state. Maladaptive equilibrium in the APAM refers to an adaptive potential state in which the individual is coping with stressors by draining energy from other subsystems. The adaptive potential state of impoverishment is an undesirable state in which the individual has severely diminished or totally depleted available coping resources (Erickson et al., 1983).

The drug addict moves from experiencing stress to a state of arousal, and then to a state of equilibrium which is usually maladaptive until finally he or she cannot cope at all. This leads to an adaptive potential state of impoverishment in which personal self-strengths are depleted. Finally, the drug addict moves back and forth from arousal to impoverishment with every stressor. The adaptive state of impoverishment places the individual at risk for biophysical, psychosocial, and spiritual impairment. It is in the state of impoverishment that professional intervention for drug addiction most often occurs.

The concept of self-care was formulated within the context that people know at some level what has made them sick or less effective. Self-care resources are two-fold:

internal and external. Self-action is the development and utilization of self-care knowledge and self-care resources. Through self-care action the individual mobilizes internal resources that will help to gain, maintain, and promote an optimal level of holistic health (Erickson et al., 1983). Internal self-care resources are self-strengths and adaptive potential. Self-strengths may include spiritual well-being and health locus of control, which would promote and enhance basic needs such as safety, security, belonging, and self-esteem. External self-care resources may be health professionals and self-help groups.

The external self-care resources, skilled health professionals, and Narcotics Anonymous assist the recovering drug addict in learning to mobilize internal self-care resources, including self-strengths and adaptive potential. Internal self-strengths include spiritual well-being and health locus of control. Although the addict will almost always respond maladaptively to the stressor, hopefully, the recovering drug addict will mobilize internal self-strengths of spiritual well-being and health locus of control and respond adaptively.

Definition of Terms

The theoretical and operational definitions for terms used in this study were as follows:

Health locus of control is the source of reinforcements for health-related behaviors which can be internal, a matter

of chance, or under the control of powerful others. Health locus of control was operationalized by scores on the Multidimensional Health Locus of Control Scale (MHLC) (Wallston & Wallston, 1978).

Spiritual well-being is the central philosophy of one's life, whether religious, anti-religious, or nonreligious, and guides the individual's conduct (Moberg & Brusek, 1984) Spiritual well-being was operationalized by scores on the Spiritual Well-Being Scale (SWB) (Paloutzian & Ellison, 1982).

Participants were people who attended Narcotics Anonymous and were 18 years or older.

Narcotics Anonymous is a nonprofit fellowship or society of men and women for whom drugs had become a major problem (Narcotics Anonymous, 1983).

Assumptions

The assumptions for this study were

1. Participants of the Narcotics Anonymous program are recovering drug addicts.

2. People perceive their health problems to be internally controlled, a matter of chance, or under the control of powerful others.

3. People use internal self-strengths as coping resources based on perceptions of stressors and their ability to mobilize those self-strengths.

4. Spiritual well-being and health locus of control are variables that can be measured.

5. Narcotic addiction is a lifelong chronic health problem.

Chapter II

Review of the Literature

The area of literature reviewed in this study included addiction; the treatment, self-help groups, and the predictors and coping resources; health locus of control; and spiritual well-being. Literature relevant to each of these is presented in this chapter.

Addiction

Addiction refers to a complex, progressive behavior pattern having a biological, psychological, sociological, and behavioral component (Donovan & Marlatt, 1988). Addiction causes tragic physical, psychological, monetary, and emotional problems every day for many addicts and their families (Krames, 1986). It affects people of all ages and socioeconomic classes. There are many types of addictions: alcohol, drug, smoking, and overeating. All addictions share the same behavior pattern: the individual's overwhelmingly pathologic involvement in or attachment to the addiction, subjective compulsion to continue the addiction, and reduced ability to exert personal control over the addiction (Donovan & Marlatt, 1988). The behavior

pattern continues despite its negative impact on the physical, emotional, and social function of the individual.

A substantial number of individuals have experimented with alcohol, tobacco, and/or drugs such as marijuana, cocaine, or opiates (Clayton, 1986). The popular media have focused on the death of talented young athletes and celebrities from drug overdoses, arrests of well-known entertainers and politicians, the attempts of family and friends to understand a starving to death through anorexia nervosa, the continued health hazards of smoking, and the multimillion-dollar treatment industry that has emerged to deal with alcohol, drug, and eating disorders (Donovan & Marlatt, 1988). The impression is that the incidence and prevalence of addictive behaviors are increasing and that these problems are affecting a variety of individuals in our society.

The popular focus on addictive behaviors has brought about positive changes. Donovan and Marlatt (1988) believe that there has been an increased focus on the addictions within research and clinical communities, and secondly, there has been a growing awareness that addictions are behaviors developed and maintained by multiple sources; they are multiple determined and multidimensional in nature.

There is a high rate of relapse across addictive behaviors, but there are a number of individuals who are able to overcome their addictions without formal help

(Schacter, 1982; Stall & Biernacki, 1986). It appears that the stages through which individuals move in the process of remission are comparable across alcohol use, opiate use, smoking, obesity, and general psychological distress.

Brownell, Marlatt, Lichtenstein, and Wilson (1986) indicate that most investigators consistently find three stages. The first involves recognition of a problem, contemplating change, becoming motivated, and making a commitment to change. The second change involves actively modifying the addictive behavior, often following a public announcement of one's attempt to change. The latter factor is important in starting a process of renegotiating the user's social identity. The individual must also initiate a form of self-control to deal with withdrawal and craving. The final stage involves the maintenance of the behavior change. This requires the continued use of coping strategies to deal with specific risks of relapse as well as with general life stress, the maintenance of a new identity as a nonaddicted individual, an integration into a nonaddictive lifestyle, the development of alternative sources of reinforcement, and the reliance on the support of significant others (Donovan & Chaney, 1985; Marlatt & Gordon, 1985; Stall & Biernacki, 1986).

This study researched recovery from drug addiction by studying participants in Narcotics Anonymous. The process

for recovery described above closely resembles the Narcotics Anonymous program.

Self-Help Groups

In the last 10 years the number of self-help organizations has quadrupled, as have the topics they address. The Public Health Service estimates that 15 million citizens have banded together in 500,000 groups to help members cope with the crucial challenges of life--marriage, divorce, destructive behaviors, sickness, joblessness, and child rearing (Leerhsen, Lewis, Pomper, Davenport, & Nelson, 1990).

The roots of mutual-aid groups go back to the frontier days of the United States. By 1900 a directory listed over 250 independent national voluntary law organizations. Those to be helped were the community in general or some specific cause or disease. The proliferation of immigration in the late nineteenth century saw the new arrivals thrust into a nation in which there were few normal services to aid in their survival (Zola, 1979). The new arrivals turned to one another. Their response was the creation of mutual-aid societies where membership was based primarily on sharing some explicit social characteristics: race, religion, or country of origin.

World War II forced a confrontation with the most massive job of rehabilitation we have ever faced, and this made certain kinds of physical handicaps no longer a

personal but a national responsibility (Zola, 1979). Infectious diseases were beginning to come under control, and people were living to middle age and beyond. Many disorders became more manifest: arthritis, diabetes, mental illness, heart disease, multiple sclerosis, stroke, and cancer. These disorders were often more disabling than immediately fatal and for which no magic cure either in prevention or in care was forthcoming (Zola, 1979). These disorders required prolonged care, thus the advent of self-help groups.

Self-help groups provide preventive services and help to expand the areas of inequality of access to care (Katz, 1979). Because membership is voluntary and participation in a group tends to heighten social competence, the individual is enabled to attain the kind of social satisfaction he or she desires (Katz, 1979). Self-help groups are supportive and supplementary. According to Katz, self-help groups' specific functions lie in the areas of (a) trying to obtain better medical and social care from public and private for their participants, (b) spreading public and professional education regarding the condition they deal with, and (c) overcoming stigma and discrimination against sufferers.

Narcotics Anonymous is a nonprofit fellowship or society of men and women for whom drugs had become a major problem (Narcotics Anonymous, 1976). Recovering drug addicts meet regularly to help each other in the recovery

process. Narcotics Anonymous is not affiliated with any other organizations; there are no initiation fees or dues, no pledges to sign, and no promises to make to anyone. Anyone may join regardless of age, race, sexual identity, creed, religion, or lack of religion (Narcotics Anonymous, 1976). The only requirement for membership is the desire to quit using drugs.

Narcotics Anonymous adopted the 12-step program for recovery developed by Alcoholics Anonymous. The 12 steps of Narcotics Anonymous result in spiritual progress resulting from daily practice. In these groups, participants discuss personal experiences and feelings at regular meetings and choose sponsors who can be called on for advice or sympathy at any hour. Anonymity is maintained. Narcotics Anonymous (1986) believes that there is therapeutic value in one addict helping another.

Health Locus of Control

The way a person perceives his control over his health may delineate how active one is in his own health care. Health Locus of Control could play a vital role as a coping mechanism in the addict's recovery from drug addiction. Health locus of control may also be a predictor of a successful recovery.

The Multidimensional Health Locus of Control Scale (MHLC) yields scores on three independent dimensions of health locus of control beliefs: internal control, chance

control, and powerful others control (Wallston & Wallston, 1978). Several studies using the MHLC have been done concerning health behavior and sick-role behavior. No studies were found that related directly to the recovering drug addict.

Huckstadt (1987) investigated the locus of control among alcoholics, recovering alcoholics, and nonalcoholics. The three groups formed the sample study, and each group consisted of 22 subjects. Subjects in each of the three groups were middle-aged males whose ages ranged from 21 to 65. The majority of the subjects in all three groups were employed, with occupations ranging from cook to attorney.

The subjects in the alcoholic and recovering alcoholic groups were recruited over a 2-month period from randomly selected AA groups. Volunteers were asked to complete a questionnaire containing demographic questions and the Drinking Locus of Control of Scale (DRIE). The DRIE measures specific expectancies of control for a variety of drinking-related behaviors. Donovan and Chaney (1985) found that the DRIE scale demonstrated convergent and discriminant validity as well as concurrent validity. They also reported satisfactory internal consistency for the scale (alpha coefficient of .77). Open-ended questions were asked concerning the length of time subjects recognized their problem with alcohol, length of time since their alcoholic

beverage, what motivated them to seek help from their alcoholism, and what kept them from drinking.

Subjects for the nonalcoholic group completed a questionnaire that contained the same demographic questions and the locus of control scale. Open-ended questions for this group concerned their values and beliefs about alcohol-related problems.

Attendance of the AA meetings, in the large midwestern metropolitan area, ranged from 10-20 members each meeting. Volunteers were recruited from each of eight meetings attended. Approximately 55% of members volunteered to participate at each meeting.

The hypothesis that alcoholics, recovering alcoholics, and nonalcoholics would differ significantly on the DRIE scores was supported by analysis of variance results [$F(2.63) = 7.39$, $p < .01$]. To determine the source of difference among the three groups, Tukey's Honesty Significant Difference Test was computed. The alcoholic group was significantly more externally oriented than the nonalcoholic group. While the recovering alcoholic group did not demonstrate a significant difference from the two groups, these subjects did score more internally than the alcoholics.

The significant difference in the DRIE scores between alcoholics and nonalcoholics suggest that the more externally oriented alcoholic may have difficulty in

maintaining sobriety. Recommendations for further study included: (a) larger samples to further investigate the trend of recovering alcoholics scoring more internally than alcoholics, (b) matched education and other socioeconomic factors, (c) longitudinal approach for the examination of changes in drinking locus of control over time, (d) change in interview format related to the reluctance of some alcoholics to complete written questionnaires, and (e) stricter controls relative to the period of time of abstinence and other sobriety factors differentiating the recovering alcoholic from the alcoholic.

Findings of this study suggested the drinking locus of control orientation of clients be examined in alcoholism treatment programs. Internally oriented people may benefit from self-care, while externally oriented clients may need a more directive approach. Although this study looked specifically at alcoholics, the same may be true for drug addicts.

Chavez and Michaels (1980) investigated the efficacy of the Health Locus of Control scale on predicting success in a behavioral treatment program for obesity. It was hypothesized that individuals considered internally oriented on the Health Locus of Control scale would remain in the treatment program longer and lose more weight than those scoring externally or intermediate.

Subjects were college students who responded to an advertisement in the student newspaper for a weight control clinic administered by the Student Health Center at Colorado State University, ranged in age from 17 to 33 years, and had weight goals ranging from 5 to 50 pounds. Forty-one returned for subsequent sessions and 22 females remained for the entire program. All returning subjects had attempted to lose weight through other methods and programs but reported failure.

Upon arrival to the introductory session, all subjects were given an index card and numerically matched questionnaire. The questionnaire of 21 true/false questions included the 11-item Health Locus of Control scale, demographic information, and a series of questions regarding eating and exercise habits, perceptions of own attractiveness, and the age at which they became overweight.

Internal persons were those individuals who responded in the internal direction to 10 or 11 of the 11-item scale (n = 31) while external persons were those responding to six or more questions in the external direction (n = 12). The internal persons (165.7, SD = 23.1) weighed significantly more than the external women (139.6, SD = 16.3; df = 41, t = 2.34, $p < .05$). There was no significant difference in length of stay in the program. Internal subjects lost significantly more weight (5.93, SD = 5.17) than did

external subjects continuing for all or part of the program (2.6, SD = 3.53; df = 39, t = 2.8, p < .05).

Although internal women were significantly heavier, they considered themselves more attractive than the externals (df = 39, t = 3.57, p < .001). There were no significant differences for age of onset, parental obesity, exercising, or self-perceptions of subjects' ability to succeed in weight programs. A follow-up study was not completed due to subjects leaving the campus.

The 31 individuals characterized as internal lost more weight. There were too few external subjects remaining to assess their performance adequately. Of the three external persons, none lost weight. The fact that internal subjects considered themselves more attractive than external ones, even though they weighed significantly more, suggests that self-concepts of overweight internal persons may be higher than those of overweight external ones. The study further suggested that internal persons should be more likely to take steps to better their environmental condition and be more successful in a program designed to modify behaviors.

Further research replicating this study was recommended. The researchers believe that development of an instrument for measuring internal-external locus of control specifically for obese persons would permit screening to facilitate treatment.

Each of these studies researched different types of addiction. It is believed that those addicts who are internals have a better chance of recovery and remaining recovered. Other research studies on addictive behaviors have supported this belief. Platt (1969) found internals able to change smoking behavior to a greater extent than externals. Steffey (1970) found internals more likely to reduce their smoking. Studies (Best, 1975; Best & Steffey, 1975) have shown type of treatment to interact with locus of control in determining treatment outcome. There have been a few studies on addictive behaviors that did not support the belief that internals have a better chance of recovery (Bellack, 1974; Best & Steffey, 1971; Lichtenstein & Keutzer, 1967). More research is needed on health locus of control for people with addictive behaviors to facilitate treatment.

Spiritual Well-Being

Spirituality is an abstract, multifaceted, human dimension that is part of every person whether religious, atheist, or humanist (Stoll, 1989). Although spirituality is often equated with a religion or doctrinal belief, spirituality and religion are not synonymous. Rather, religious activities serve as a vehicle for the expression of one's spirituality. All individuals pursue an object of worship, whether an unconscious god, created beings, or a personal God.

Ellison (1983) described the human spirit as that which enables and motivates individuals to search for meaning and purpose in life, to seek some meaning which transcends, and to wonder about their origins and identity. Spirituality is man's inner resources, his ultimate concern, the basic value around which all other values are focused. It is the central philosophy of life that guides a person's conduct (Moberg, 1984). The spirit synthesizes the total personality and integrates the biophysical and psychosocial components of man.

Paloutzian and Ellison (1982) developed the Spiritual Well-Being Scale (SWB) to measure levels of religious well-being (RWB) and existential well-being (EWB). The SWB Scale is a 20-item instrument with 10 questions for each of the two subscales. Ellison recommended more work on how spiritual well-being relates to other psychosocial and social variables. No studies have been conducted on the level of spiritual well-being of recovering drug addicts.

Spiritual well-being is an important coping resource. Narcotics Anonymous speaks to a higher power in a number of the 12 steps. For example: "We came to believe that a Power greater than ourselves could restore us to sanity," and "We made a decision to turn our will and our lives over to the care of God as we understand Him" (Narcotics Anonymous, 1983). Narcotics Anonymous can be that higher power. According to Twelve Steps and Twelve Traditions

(Alcoholics Anonymous, 1981), many new members find faith in the program, recovered addicts, etc., but all of them will tell you that once across the initial steps of recovery their faith broadened and deepened. Relieved of the alcohol or drug obsession, their lives unaccountably transformed, they came to believe in a Higher Power.

Spiritual well-being is satisfaction with one's life in a relationship with God, however god is defined, and a perception of life as having meaning. Spiritual well-being is an indicator of spiritual health and is positively related to psychosocial well-being. Spiritual well-being may be an effective coping resource for the recovering drug addict during recovery from drug addiction.

Chapter III

The Research Design

The purpose of this investigation was to ascertain the relationship between health locus of control and level of spiritual well-being of participants in Narcotics Anonymous; therefore, the design chosen for this study was descriptive correlational. Descriptive studies are conducted for the purpose of accurately portraying a population that has been targeted because of some specific characteristics (Wilson, 1989). The population targeted in this study was participants in Narcotics Anonymous. Correlational surveys are designed to discover the direction and magnitude of relationships among variables in a particular population of subjects (Wilson, 1989). This study explored relationships among demographic characteristics, health locus of control, and level of spiritual well-being of participants in Narcotics Anonymous. Two open-ended questions were included in the survey to elicit qualitative information.

Variables

Three variables were of interest in this study. The criterion variable was participants in Narcotics Anonymous. The two predictor variables in this study were spiritual

well-being as determined by scores on the Spiritual Well-Being Scale (SWB) and health locus of control as measured by scores on the Multidimensional Health Locus of Control Scale (MHLC). The controlled variables included age and a history of drug abuse. Intervening variables may have included truthfulness and time constraints.

Setting, Population, and Sample

The setting for this study was local Narcotics Anonymous meetings in northeastern and central Mississippi. The communities are predominantly rural. The primary income is from farming and small industry. There are several active Narcotics Anonymous support groups who conduct open and closed meetings. There is one major chemical dependency treatment center in this area.

The sample of convenience was participants in the local Narcotics Anonymous meetings who voluntarily completed the questionnaires. Criteria used for selection of the participants were that they were 18 years or older and recovering drug addicts. All Narcotics Anonymous participants who met the criteria, agreed to participate, and were present during data collection were included. Twenty men and women participated in the study.

Data-Gathering Process

Approval to conduct the research was granted from the Mississippi University for Women Committee on Use of Human

Subjects in Experimentation (see Appendix A). Permission was granted from Dr. Wallston to utilize the MHLC (see Appendix B), and from Dr. Paloutzian to utilize the SWB (see Appendix C) in the study. After the appropriate approval was granted, a participant in Narcotics Anonymous was contacted to act as gatekeeper to facilitate researcher access to members to conduct the study. In order to maintain anonymity of the Narcotics Anonymous members, the local group leader (gatekeeper) requested the researcher not attend the meetings and allow the gatekeeper to present the study. The purpose and instruments for the study were explained to the gatekeeper, questions were answered, and the predetermined format of administering the instruments was related.

The gatekeeper presented the research study to the members at each meeting, and they decided as a group to accept the study. Different Narcotics Anonymous groups met anywhere from one day a week to seven days a week. A form (see Appendix D) explaining the purpose of the research, questionnaires used, and inviting them to participate was provided to each Narcotics Anonymous member. To maintain anonymity, no consent form was signed, and no names appeared on the questionnaires. Willingness to enter the study was indicated by completion of the three instruments. The gatekeeper gave the Demographic Data Sheet with two qualitative questions, the SWB Scale, and the MHLC Scale to

each volunteer to complete. Completed answer sheets were returned to the gatekeeper and placed in an envelope. It took approximately 30 minutes for the instruments to be answered. Data collection occurred between August 21, 1990, and September 30, 1990.

Instrumentation

Data were collected using three instruments, the Demographic Data Sheet, the Spiritual Well-Being Scale (SWB), and the Multidimensional Health Locus of Control Scale (MHLC). The Demographic Data Sheet (see Appendix E) was a self-administered instrument developed by the researcher to collect pertinent data pertaining to the characteristics of the participants. The tool was designed to obtain information in the following domains: (a) age, (b) sex, (c) race, (d) religion, (e) education, (f) marital status, (g) children, (h) number of years addicted, and (i) months attending Narcotics Anonymous. The Demographic Data Sheet also included two open-ended questions about the participant's recovery from drug abuse.

The SWB (see Appendix F) measured the level of spiritual well-being. It consisted of 20 items responded to on a 6-point Likert scale which yielded three scores: (a) a total SWB score, (b) a religious well-being score (RWB), and (c) an existential well-being score (EWB) (Paloutzian & Ellison, 1982). These items were rated along a 6-point scale with respondents indicating Strongly Agree (6),

Moderately Agree (5), Agree (4), Disagree (5), Moderately Disagree (2), and Disagree (1). Some of the statements are positively worded while others are negatively worded.

The SWB was developed by psychologists Paloutzian and Ellison (1982) to measure two dimensions of spirituality: religious well-being and existential well-being. Preliminary versions of the SWB were tested and revised to a final version which contains 10 religious items (odd-numbered items) and 10 existential items (even-numbered items). Scores for the two subscales were summed to provide an overall measure of SWB. The higher the score, the higher the level of spiritual well-being. The highest score possible for the total SWB was 120 and 60 for each subscale.

The correlation between the subscales has ranged from .62 ($p < .001$) in two experiments with the initial 15-item version of the scale to .32 ($p < .001$) for the revised scale. Test-retest reliability coefficients obtained from 100 student volunteers at the University of Idaho (Paloutzian & Ellison, 1982) were .89 (SWB), .96 (RWB), and .78 (EWB). Coefficient alphas, an index of internal consistency, were .89 (SWB), .87 (RWB), and .78 (EWB). The magnitude of these coefficients suggested that SWB has high reliability and internal consistency.

Content validity of the SWB was suggested from the examination of the items by a panel of experts. The SWB scores correlated as predicted with several other scales;

individuals who scored high on the SWB tended to be less lonely, more socially skilled, have higher self-esteem, and were more intrinsic in their religious commitment (Paloutzian & Ellison, 1982).

The Multidimensional Health Locus of Control Scale (MHLC) (see Appendix G) measured the relationship between an individual's health behaviors and that person's belief about the locus of health control. It consisted of 18 items responded to on a 6-point Likert scale which measured three distinct dimensions: (a) internality (IHLC), (b) chance externality (CHLC), and (c) powerful others externality (PHLC) (Wallston & Wallston, 1978). Items numbers 1, 6, 8, 12, 13, and 17 indicated internal health locus of control. Item numbers 2, 4, 9, 11, 15, and 16 indicated chance locus of control. Item numbers 3, 5, 7, 10, 14, and 18 indicated powerful other health locus of control. The Likert scale ranged from Strongly Agree (6) to Strongly Disagree (1).

The MHLC was developed by Kenneth Wallston, Barbara Wallston, and Robert DeVellis to tap beliefs that the source of reinforcements for health-related behaviors is primarily internal, a matter of chance, or under the control of powerful others. These scales were based on earlier work with a general health locus of control scale. Each subscale was summed and the subscale with the highest score indicated the person's health locus of control. The highest possible score for each subscale was 36.

Alpha reliabilities for the MHLC scale ranged from .67 to .77 (Wallston & Wallston, 1981). As an initial indication of predictive validity, correlations were computed between health status and the MHLC scores. As expected, health status correlated positively with IHLC (r = .403, $p < .001$), negatively with CHLC (r = -.275, $p < .01$), and did not correlate with PHLC (r = -.055) (Wallston & Wallston, 1978). Examination of the item content suggested good face validity.

Methods of Data Analysis

Descriptive statistics of means and standard deviation were used to describe each demographic variable. The Pearson Product Moment Correlation was used to determine the relationship between and among the variables. The two open-ended questions were analyzed by content analysis.

Analysis was guided by the research questions. The research questions of data derived from the instruments were:

1. What is the health locus of control of participants in Narcotics Anonymous? This question was answered using descriptive statistics to determine the health locus of control of the sample. Means and standard deviations were computed on the raw scores of each of the three subscales.

2. What are the level and dimension of spiritual well-being of participants in Narcotics Anonymous? This

question was answered using descriptive statistics to determine the level of spiritual well-being in the sample. Means and standard deviations were computed on the raw scores of the total SWB and for each of the two subscales to determine the dimensions of spiritual well-being.

3. What is the relationship between health locus of control and level of spiritual well-being of participants in Narcotics Anonymous? This question was answered using the Pearson Product Moment Correlation procedure to determine the relationship.

4. What are the relationships between age, months attending Narcotics Anonymous, years addicted to drugs and locus of control and spiritual well-being of participants in Narcotics Anonymous? This was answered using the Pearson Product Moment Correlation procedure to determine the relationship. Descriptive statistics were used to determine other demographic characteristics.

5. The two open-ended questions were answered using content analysis.

Chapter IV

Analysis of Data

The purpose of this descriptive correlational study was to determine the relationship between health locus of control and spiritual well-being of participants in Narcotics Anonymous. The health locus of control and the level and dimension of spiritual well-being for participants in this study were determined. Relationships among age, months attending Narcotics Anonymous, year addicted and health locus of control and spiritual well-being were explored. Erickson, Tomlin, and Swain's Modeling and Role-Modeling provided the conceptual framework. In this chapter the sample is described, results of data analyzed, and additional findings are presented.

Description of the Sample

The voluntary sample of convenience consisted of 8 males (40%) and 12 females (60%) over 18 years of age who were recovering drug addicts and participants in Narcotics Anonymous. The mean age of the sample was 31.85 years (*SD* = 10.6). The age range was 21 to 63, with the mode being 28 years. All participants were white and 45% (*n* = 9) had attended some college, 25% (*n* = 5) had a college degree, 15%

(n = 3) graduated from high school, 10% (n = 2) had a graduate degree, and 5% (n = 1) had attended some high school.

Forty percent (n = 8) of the same were married, 35% (n = 7) were single, 10% (n = 2) were divorced, 5% (n = 1) were separated, and 5% (n = 1) were widowed. One participant did not respond to the marital status question. The religious preference for 90% (n = 18) of participants was Christian. One participant reported to be an atheist, and one did not answer the question. One participant indicated a nondenominational religious preference, but for reporting purposes was included with the Christians.

The mean number of months for attending Narcotics Anonymous was 30 (SD = 32.2). The range was from less than one month to 105 months. The mean number of years the participants were addicted to drugs was 12.2 years (SD = 9.25). The range was from 2 to 40 years. See Appendix H for the raw data.

Results of Data Analysis

Four research questions and two open-ended questions guided this study.

1. What is the health locus of control of participants in Narcotics Anonymous? This question was answered using descriptive statistics. Means and standard deviations were computed on the raw scores of each of the subscales (see Table 1). The mean score for the internal

subscale (IHLC) and the powerful others subscale (PHLC) were high, and the chance subscale (CHLC) scores were low. The scores for the IHLC ranged from 8 to 36. Scores ranged from 6 to 23 for the CHLC and from 6 to 26 for the PHLC.

Table 1

Health Locus of Control of Participants

Variable	*M*	*SD*
IHLC	26*	5.75
PHLC	20*	4.50
CHLC	16**	4.42

Note. *N* = 20.

*High: *M* = ≥ 18. **Low: *M* = ≤ 18.

2. What are the level and dimension of spiritual well-being of participants in Narcotics Anonymous? This question was answered using descriptive statistics. Means and standard deviations were computed on the raw scores of the total SWB and for each of the two subscales to determine the dimensions of spiritual well-being. The total SWB, the RWB, and EWB scores were high (see Table 2). The SWB scores ranged from 69 to 120. The RWB range was from 33 to 60 and the EWB range was from 33 to 60.

Table 2

Level and Dimension of Spiritual Well-Being of Participants

Variable	M	SD
SWB	96	15.14
RWB	50	8.46
EWB	46	7.48

Note. N = 20.

3. What is the relationship between health locus of control and level of spiritual well-being of participants in Narcotics Anonymous? The Pearson Product Moment Correlation procedure was used to determine the relationship. Chance locus of control (CHLC) correlated negatively with SWB, RWB, and EWB. Table 3 summarized this correlation.

Table 3

Relationship Between Health Locus of Control and Level of Spiritual Well-Being

Variable	SWB	EWB	RWB
IHLC			
r	.141	2.692	.287
CHLC			
r	.557*	- .695*	-.608*
PHLC			
r	-.262	- .329	-.177

Note. *N* = 20.

*$p \leq .05$.

4. What are the relationships between age, months attending Narcotics Anonymous, years addicted to drugs and health locus of control and level of spiritual well-being of participants in Narcotics Anonymous? This question was answered using the Pearson Product Moment Correlation procedure. There was no significant correlation found between age, months attending Narcotics Anonymous, or years addicted to drugs and health locus of control. Table 4 summarized this data.

Table 4

Relationship of Health Locus of Control and Demographic Characteristics

Variable	Age	Months Attending	Years Addicted
IHLC			
r	-.280	-.181	-.346
CHLC			
r	-.260	-.362	-6.060
PHLC			
r	.333	.182	.169

Note. *N* = 20.

*$p \leq .05$.

There was no significant correlation found between age, months attending Narcotics Anonymous, or years addicted to drugs and spiritual well-being. Table 5 summarizes this power.

Table 5

Relationship of Spiritual Well-Being and Demographic Characteristics

Variable	Age	Months Attending	Years Addicted
SWB			
r	.361	.388	.340
RWB			
r	.355	.374	.435
EWB			
r	.329	.363	.154

Note. *N* = 20.

*$p \leq .05$.

5. The two open-ended questions were answered using content analysis. The participants' answers to the two questions were examined for recurring themes. These themes were identified and placed in categories. The frequency for each category was determined. Three recurring themes were identified for reasons for seeking help: personal, legal, and family issues. Table 6 summarizes this data:

Table 6

Reasons for Seeking Help

Category	f	%
Personal issues	9	45
Legal issues	8	40
Family issues	3	15

Note. N = 20.

Three recurring themes were identified for one's major influence in recovery: Narcotics Anonymous, a counselor, and a family member. Table 7 summarizes this data.

Table 7

Major Influence on Recovery

Category	f	%
Narcotics Anonymous	16	80
Counselor	3	15
Family	1	5

Additional Findings

Females (n = 12) scored higher than males (n = 8) on the SWB scale. Divorced participants (n = 2) scored highest on the SWB scale. The one participant with "Some high

school" scored 104 on the SWB and the participants with "Some college" (n = 9) scored 103, for the highest scores on the SWB related to education.

Females scored highest on the IHLC subscale, while males scored highest on the CHLC and PHLC subscales. Single (n = 7) participants scored highest on the IHLC subscale, widowed (n = 1) on the CHLC subscale, and married (n = 8) on the PHLC subscale. Those participants with some college (n = 9) scored highest on the IHLC subscale, college graduates (n = 5) scored highest on the CHLC subscale, and those with some high school (n = 1) scored highest on the PHLC subscale. The atheist scored highest on the IHLC subscale. Christians (n = 18) scored higher on the CHLC subscale, and both Christian and atheist scored the same on the PHLC subscale. Appendix I summarizes the demographic data in relation to the MHLC scale and the SWB scale.

Seventy percent (n = 14) had attended Narcotics Anonymous for 12 months or greater. Although there was no significant relationship between years attending Narcotics Anonymous and health locus of control and spiritual well-being, those attending Narcotics Anonymous longer did score higher on the SWB scale.

Limitations

The following limitations were identified for this study:

1. The nonrandomized and small sample size prevents generalization of the findings.

2. Although the small sample size was representative of participants in Narcotics Anonymous in this geographic location, generalization of these findings must be made with caution.

Chapter V

The Outcomes

According to the National Institute on Drug Abuse (Consumers' Research, 1988), cocaine use has become one of the major social and health problems in this country; studies show that 4 to 6 million Americans are compulsive users of cocaine. There is often a high rate of relapse during the first 3 months of recovery (Donovan & Marlatt, 1988). Few research studies have been conducted that focus on the recovering drug addict. The purpose of this descriptive correlational study was to explore the relationship between health locus of control and level of spiritual well-being of participants in Narcotics Anonymous. The health locus of control and level and dimension of spiritual well-being for participants in this study were determined. Relationships among age, months attending Narcotics Anonymous, years addicted and health locus of control and spiritual well-being were explored.

Erickson et al.'s (1983) Modeling and Role-Modeling provided the conceptual framework for this study. Data were collected using the Multidimensional Health Locus of Control Scale (MHLC), the Spiritual Well-Being Scale (SWB), and a Demographic Data Sheet. These questionnaires were

administered to 20 men and women, 18 years and older, who were participants in Narcotics Anonymous. Anonymity was maintained by using a gatekeeper to collect data. No name appeared on the questionnaires, and a consent form was not signed. Completion of the questionnaires indicated willingness to participate.

Discussion

There were four research questions and two open-ended questions answered in this study. Descriptive statistics, Pearson Product Moment Correlation procedure, and content analysis were used to analyze the data.

The sample consisted of 20 participants in Narcotics Anonymous. All participants were white, most were married, and most were young adults. The sample was well-educated and 90% indicated a Christian religious preference. On the average, the participants had attended Narcotics Anonymous for 1 1/2 years. The average number of years the participants were addicted to drugs was 12.

The health locus of control for the group was determined internal because the participants scored highest on the internal subscale (M = 25.65, SD = 5.75). Wallston and Wallston (1978) recommended splitting the subscales at the median. Scores above the median were high and those below the median were low. The median score for each subscale was 18. The participants scored high on the

internal subjects (M = 25.65; SD = 5.75) and powerful others subscale (M = 19.8; SD = 4.50). They scored low on the chance subscale (M = 16.35; SD = 4.42). Wallston and Wallston (1978) acknowledge that the high scores on the powerful others subscale may indicate confusion in that respondents believe that powerful others refers to God or other higher being. In the Narcotics Anonymous twelve-step program, the term powerful others refers to the God or their God as they understand Him. The participants in this study, too, could have confused powerful others with God or a higher power.

The level of spiritual well-being for the participants was determined to be nonimpaired. Paloutzian and Ellison (1982) recommended splitting the subscales and the total score at the median. SWB was considered nonimpaired if scores were above 60; RW and EWB were considered nonimpaired if scores were above 30. All participants scored above the 50th percentile on the total SWB (M = 96.15, SD = 7.48) and the two subscales, RWB (M = 50.15, SD = 8.46) and EWB (M = 46, SD = 7.48); therefore, all participants were nonimpaired spiritually. The scores were most homogeneous on the EWB subscale (SD = 7.48). This would be expected because of the nature of support groups. Support groups ban together to lend support, listen, give advice from experience, and help each other. There is an increase in self-esteem and self-pride when one discovers that there are others with the same

problem and that he or she cannot only get assistance but give advice and support to others.

A significant negative relationship was found between chance health locus of control and spiritual well-being (r = -0.557), religious well-being (r = -0.608), and existential well-being (r = -.695). This would be expected because of the level of spiritual well-being among the group. Nonimpaired levels of SWB appear to counter-influence chance health locus of control. Chance health locus of control is an external locus of control; therefore, one is believed to have less self-control over their life and rely on fate. Higher levels of spiritual well-being suggest one is more likely to take control of his/her life and destination.

No significant relationship was found between age, months attending Narcotics Anonymous, years addicted and health locus of control and level of spiritual well-being. Those participants who had attended Narcotics Anonymous longer did score higher on the SWB scale, suggesting that spiritual well-being may be higher for those recovering drug addicts participating in support groups over time or persons with higher levels of spiritual well-being remain in Narcotics Anonymous. Education, sex, marital status, or religious preference appeared to make no significant difference in the scores on the SWB or MHLC.

Three recurring themes were determined for the first open-ended question: personal, legal, and family. Personal

(n = 9) and legal (n = 8) were the reasons given most often for seeking help. Several stated that they were sick and tired of being sick and tired and finally sought help. Some were ordered by the court to seek help and several had lost their driver's license. Three participants gave failing marital relationships or prompting by close family members as their reasons for seeking help. According to Modeling and Role-Modeling's Adaptive Potential Assessment Model (APAM) (Erickson et al., 1983) it is in the state of impoverishment that one finally cannot cope at all. Personal self-strengths are depleted. It is the state of impoverishment that professional intervention for drug addiction most often occurs--when that drug addict is sick and tired.

Three recurring themes were also determined for the second open-ended question: Narcotics Anonymous, a counselor, and family. These were given as the major influence in the participants' recovery from drug addiction. Overwhelmingly, Narcotics Anonymous was given by 16 participants (80%) as the major influence in their recovery. This suggests that Narcotics Anonymous is an important external coping resource.

Conclusions

This study did support the belief of Platt (1969), Steffey (1970), and Best (1975) that internals have a better chance of recovery. Seventy percent (n = 14) had been

attending Narcotics Anonymous for at least 12 months or greater. Internal health locus of control and spiritual well-being do appear to be important internal self-strengths mobilized by the recovering drug addict when dealing with stressors. This study suggests that fostering internal self-strengths, such as health locus of control and spiritual well-being, may promote more effective treatment for the recovering drug addict. It further suggests that Narcotics Anonymous could be an important external coping resource. This study lends credence to Modeling and Role-Modeling's Adaptive Potential Model (APAM) (Erickson et al., 1983).

Implications for Nursing

Several implications for nursing evolved from this research endeavor:

1. Education. More information about addictive disorders should be included both in undergraduate and graduate curricula.

2. Practice. Nurses at every level deal with addictive disorders in their daily practice. Recognizing the addict's locus of control and level of spiritual well-being may suggest which treatment modalities may be most successful. It may be necessary to assist the addict in identifying what they want and need in order to mobilize their self-care coping resources.

3. Research. Very little nursing research had been conducted related to the care of the recovering drug addict. Research is needed to better understand the complicated process of addiction and recovery to facilitate treatment.

Recommendations

Based on the findings of this research, the following recommendations are made:

1. Replication of this study using a larger sample size.

2. Replication of this study comparing recovering drug addicts who attend Narcotics Anonymous and those recovering drug addicts who do not.

3. Exploratory study to identify successful treatment modalities other than Narcotics Anonymous such as treatment centers.

4. A longitudinal study through recovery and over time in Narcotics Anonymous.

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APPENDICES

APPENDIX A

APPROVAL OF COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION

MISSISSIPPI UNIVERSITY FOR WOMEN
Columbus, MS 39701

Vice President for Academic Affairs
P.O. Box W-1603
(601) 329-7142

March 21, 1990

Ms. Melinda Hamlin
Division of Nursing
Campus

Dear Ms. Hamlin:

The Committee on Use of Human Subjects in Experimentation has recommended approval of your proposal "Relationship Between Health Locus of Control and Spiritual Well-Being of Participants in Narcotics Anonymous." I am happy to approve their recommendation.

Sincerely,

Dorothy Burdeshaw

Dorothy Burdeshaw
Interim Vice President
for Academic Affairs

DB:wr

cc: Mrs. Mary Pat Curtis

APPENDIX B

PERMISSION TO USE THE MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL SCALE

VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37240 TELEPHONE (615) 322-7311

Health Care Research Project • School of Nursing • Direct phone 322-2520

To: Fellow Health Researcher
From: Kenneth A. Wallston, Ph.D.

Thank you for your interest in the Health Locus of Control Scales. Please excuse this form response, but I have so many inquiries requiring similar replies that I have found this to be an efficient means of disseminating information.

You have my permission to utilize Form A or B of the MHLC scales in any health related research you are doing. My only request is that you keep me informed of any results you obtain using the scales. In that way I hope to continue to serve as a clearinghouse for information about the scales.

We are currently in the process of developing Form C of the MHLC scales, an instrument which can easily be made specific to any existing medically-related condition which your subjects might have (e.g., diabetes, cancer, high blood pressure, migraine headaches, arthritis, chemical dependencies, etc.) We have used Form C as an "Arthritis Locus of Control Scale" and are generally pleased with its psychometric properties. If you think such an instrument would be helpful in your research and if you are willing to share your data back with us, we would be pleased to make it available to you.

We have put many of the studies that have been done with the HLC/MHLC scales on a computerized database coded into 22 different fields. Thus, should you or any other investigator wish to know "how many studies have been done using Form A with an N > 100 with male subjects predicting smoking behavior?," we have the capability of searching the database and seeing which studies fit that description. There is a charge of $25 for each search and report that we do; however, we will refund $20 if the search comes up with nothing useful.

If you wish to be added to our mailing list or want additional material, please complete and return the enclosed interest questionnaire. For some items there is a small charge to cover duplication and postage. I hope to periodically send updated information related to the use of these scales as it becomes available.

If you have more specific questions, don't hesitate to contact me. Please remember to send me information on any use you make of these scales. I have included a usage questionnaire to facilitate your doing so. I look forward to hearing from you.

2/89

APPENDIX C

PERMISSION TO USE THE SPIRITUAL WELL-BEING SCALE

Melinda R. Hamlin, RNC, B.S.N.
Route 2 Box 168
Rienzi, Mississippi 38365
Phone: 601-462-5302 (home)
601-286-6351 (work)

Dr. Raymond Paloutzian
Psychology Department
955 Lapage Road
Santa Barbara, California 93108-1099

Dear Dr. Paloutzian

My name is Melinda Hamlin, and I am a graduate student at the Mississippi University for Women in Columbus, Mississippi. I would like to use your Spiritual Well-Being Scale for my research. I have chosen to explore the level of spiritual well-being and health locus of control of recovering drug addicts who are members of Narcotics Anonymous.

I would appreciate your written permission to utilize your tool for this purpose. I will be glad to send you a copy of the completed research. My anticipated date of graduation is August, 1990. Please let me know if I need to do anything else.

Sincerely,

Melinda R. Hamlin, RNC, BSN

Melinda R. Hamlin, RNC, B.S.N.

Dear Ms. Hamlin:
You may use the SWB Scale in your research. As noted above, please inform me of your research and results. Enclosed is an article on Norms for the SWB, which you will want to use
—R. Paloutzian

APPENDIX D

CLIENT CONSENT FORM

Client Consent Form

Your are invited to participate in a study about recovering drug addicts who participate in Narcotics Anonymous. My name is Melinda Hamlin, and I am a graduate student at Mississippi University for Women, School of Nursing in Columbus, Mississippi. I am conducting this study as part of the requirements for a Master's degree. I hope to learn more about the recovering drug addict, which will help health professionals assist with recovery.

If you decide to participate, you will be asked to complete three different questionnaires about what you feel has been important in your recovery from drug addiction. The questionnaires will take about 30 minutes to complete. This is strictly voluntary. The only criteria for participation is that you are a participant in Narcotics Anonymous and 18 years or older.

No risks to any of the participants in this study is anticipated. The only inconvenience that you might encounter is the time involved in completing the questionnaires. The study has no direct benefit to you, but the information you provide will help us gain more understanding of the recovering drug addict.

Any information obtained in connection with this study is confidential. Anonymity is assured. No names will appear on the questionnaires; the information will be reported together as a group. There will be no way of identifying you with your answers. The information will be used to write a master's thesis and will be destroyed following completion of the study.

You are under no obligation to participate in this study. To maintain anonymity, you will not be asked to sign this consent form. Completing the questionnaires will show your willingness to participate.

The results of this research will be made available to you, if you wish. Please leave your name and address with me, and I will mail you the results of the study. If you have any questions, please ask me. If you have additional questions later, please contact me.

Melinda Hamlin, RNC, BSN
Route 2, Box 16B
Rienzi, MS 38865
(601) 462-5302

APPENDIX E

DEMOGRAPHIC DATA SHEET

Demographic Data Sheet

Directions:

1. Do not put your name on this form.
2. Answer each question by checking the block that is most accurate or completing the blank.

1. Date of Birth: _____/_____/_____ (Month Day Year)

2. Race
   - ____ White
   - ____ Black
   - ____ Hispanic
   - ____ Other (write in):_____

3. Sex
   - ____ Male
   - ____ Female

4. Marital Status
   - ____ Married
   - ____ Separated
   - ____ Divorced
   - ____ Widow
   - ____ Single

5. Number of Children
   - ____ 0
   - ____ 1-5
   - ____ 6-10
   - ____ Over 10

6. When did you begin attending NA? _____/_____ (Month year)

7. Number of years addicted to drugs: _____

8. Education Level (check highest level completed):
   - ____ 9th grade or less
   - ____ Some high school
   - ____ High school graduate
   - ____ Some college
   - ____ College graduate
   - ____ Some graduate college
   - ____ Graduate degree

9. Religious Affiliation:
   - ____ Protestant
   - ____ Catholic
   - ____ Jewish
   - ____ Other (write in):_____

Questions: Please answer the following questions as openly and completely as possible. Remember all answers are anonymous. If extra space is needed, please use back.

1. What prompted you to come to N.A.?

2. What or who has been the major influence in your recovery from addiction? Why?

THANK YOU FOR YOUR ASSISTANCE!

APPENDIX F

SPIRITUAL WELL-BEING SCALE

Spiritual Well-Being Scale

Directions:
1. Do not put your name on this form.
2. For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

1.	I don't find much satisfaction in private prayer with God.	SA	MA	A	D	MD	SD
2.	I don't know who I am, where I came from, or where I'm going.	SA	MA	A	D	MD	SD
3.	I believe that God loves me and cares about me.	SA	MA	A	D	MD	SD
4.	I feel that life is a positive experience.	SA	MA	A	D	MD	SD
5.	I believe that God is impersonal and not interested in my daily situations.	SA	MA	A	D	MD	SD
6.	I feel unsettled about my future.	SA	MA	A	D	MD	SD
7.	I have a personally meaningful relationship with God.	SA	MA	A	D	MD	SD
8.	I feel very fulfilled and satisfied with life.	SA	MA	A	D	MD	SD
9.	I don't get much personal strength and support from my God.	SA	MA	A	D	MD	SD
10.	I feel a sense of well-being about the direction my life is headed in.	SA	MA	A	D	MD	SD
11.	I believe that God is concerned about my problems.	SA	MA	A	D	MD	SD
12.	I don't enjoy much about life.	SA	MA	A	D	MD	SD
13.	I don't have a personally satisfying relationship with God.	SA	MA	A	D	MD	SD
14.	I feel good about my future.	SA	MA	A	D	MD	SD
15.	My relationship with God helps me not to feel lonely.	SA	MA	A	D	MD	SD
16.	I feel that life is full of conflict and unhappiness.	SA	MA	A	D	MD	SD
17.	I feel most fulfilled when I'm in close communion with God.	SA	MA	A	D	MD	SD
18.	Life doesn't have much meaning.	SA	MA	A	D	MD	SD
19.	My relation with God contributes to my sense of well-being.	SA	MA	A	D	MD	SD
20.	I believe there is some real purpose for my life.	SA	MA	A	D	MD	SD

APPENDIX G

MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL SCALE

Multidimensional Health Locus of Control Scale

Directions:
1. Do not put your name on this form.
2. For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

1.	If I become sick, I have the power to make myself well again.	SA	MA	A	D	MD	SD
2.	Often I feel that no matter what I do, if I am going to get sick, I will get sick.	SA	MA	A	D	MD	SD
3.	If I see an excellent doctor regularly, I am less likely to have health problems.	SA	MA	A	D	MD	SD
4.	It seems that my health is greatly influenced by accidental happenings.	SA	MA	A	D	MD	SD
5.	I can only maintain my health by consulting health professionals.	SA	MA	A	D	MD	SD
6.	I am directly responsible for my health.	SA	MA	A	D	MD	SD
7.	Other people play a big part in whether I stay healthy or become sick.	SA	MA	A	D	MD	SD
8.	Whatever goes wrong with my health is my own fault.	SA	MA	A	D	MD	SD
9.	When I am sick, I just have to let nature run its course.	SA	MA	A	D	MD	SD
10.	Health professionals keep me healthy.	SA	MA	A	D	MD	SD
11.	When I stay healthy, I'm just plain lucky.	SA	MA	A	D	MD	SD
12.	My physical well-being depends on how well I take care of myself.	SA	MA	A	D	MD	SD
13.	When I feel ill, I know it is because I have not been taking care of myself properly.	SA	MA	A	D	MD	SD
14.	The type of care I receive from other people is what is responsible for how well I recover from an illness.	SA	MA	A	D	MD	SD
15.	Even when I take care of myself, it's easy to get sick.	SA	MA	A	D	MD	SD
16.	When I become ill, it's a matter of fate.	SA	MA	A	D	MD	SD
17.	I can pretty much stay healthy by taking good care of myself.	SA	MA	A	D	MD	SD
18.	Following doctor's orders to the letter is the best way for me to stay healthy.	SA	MA	A	D	MD	SD

APPENDIX H

RAW DATA SCORES

Raw Data Scores

Subject	Age	Race[a]	Sex[b]	Marital Status[c]	ATTE (Months)[d]	ADDI (Years)[e]	EDU[f]	RELI[g]	Scores RWB	EWB	SWB	IHLC	CHLC	PHLC
1	27	1	1	5	2	15	4	1	54	47	101	27	22	20
2	31	1	2	5	60	20	2	1	60	44	104	28	15	24
3	40	1	1	3	51	25	3	1	55	58	113	8	17	18
4	54	1	2	-	89	6	4	1	60	59	119	24	11	19
5	63	1	1	1	89	40	7	1	59	50	109	24	14	26
6	36	1	2	3	12	21	5	1	58	45	103	28	18	21
7	31	1	2	2	14	15	5	1	43	35	78	25	17	12
8	31	1	2	5	15	2	5	1	41	39	80	21	20	18
9	21	1	1	5	19	8	4	4	55	48	103	28	14	19
10	28	1	2	1	0	12	7	-	46	47	93	24	14	18
11	26	1	1	1	9	10	5	1	35	33	68	22	23	22
12	28	1	1	1	105	12	5	1	45	42	87	28	18	21
13	28	1	1	1	3	2	3	1	33	36	69	25	22	26
14	28	1	2	1	5	3	4	1	50	45	95	33	19	21
15	40	1	1	1	44	10	3	1	48	47	95	21	9	24
16	29	1	2	4	18	15	4	1	47	42	89	22	19	21
17	22	1	2	5	28	7	4	4	60	60	120	36	6	6
18	22	1	2	5	13	6	4	1	43	44	87	28	20	20
19	27	1	2	1	17	12	4	1	60	53	113	31	15	20
20	25	1	2	5	7	2	4	1	51	46	97	30	14	20

[a]Race: 1 = White. [b]Sex: 1 = Male, 2 = Female. [c]Marital Status: 1 = Married, 2 = Separated, 3 = Divorced, 4 = Widowed, 5 = Single. [d]ATTE: Months attended NA. [e]ATTI: Years addicted. [f]EDU = Education: 1 = 9th grade or less, 2 = Some high school, 3 = High school graduate, 4 = Some college, 5 = College graduate, 6 = Some graduate college, 7 = Graduate degree. [g]RELI = Religion: 1 = Protestant, 2 = Catholic, 3 = Jewish, 4 = Other.

APPENDIX I

SWB AND MHLC MEANS AND STANDARD DEVIATIONS FOR DEMOGRAPHIC VARIABLES

SWB and MHLC Means and Standard Deviations

for Demographic Variables

Demographic Characteristic	RWB	EWB	SWB	I	C	P
Education (N = 20)						
Some HS						
n = 1 (5%)						
M	60.00	44.00	104.00	28.00	15.00	24.00
SD	-	-	-	-	-	-
HS Grad						
n = 3 (15%)						
M	45.00	47.00	92.00	18.00	16.00	23.00
SD	11.24	11.00	22.12	8.89	6.56	4.16
Some College						
n = 9 (45%)						
M	53.00	49.00	103.00	29.00	16.00	18.00
SD	6.00	6.52	12.25	4.32	5.03	4.72
College Graduate						
n = 5 (25%)						
M	42.00	39.00	83.00	25.00	19.00	19.00
SD	9.83	5.00	13.00	3.27	2.39	4.09
Graduate Degree						
n = 2 (10%)						
M	52.50	48.50	101.00	24.00	14.00	22.00
SD	-	-	-	-	-	-
Religion (N = 19)*						
Christian						
n = 18 (90%)						
M	50.00	46.00	96.00	26.00	17.00	19.00
SD	8.80	7.88	15.00	6.04	4.59	5.72
Atheist						
n = 1 (5%)						
M	55.00	48.00	103.00	28.00	14.00	19.00
SD	-	-	-	-	-	-

*One did not answer.

Demographic Characteristic	RWB	EWB	SWB	I	C	P
			Sex (N = 20)			
Male						
n = 8 (40%)						
M	48.00	45.00	93.00	23.00	17.00	22.00
SD	9.67	8.44	17.15	6.56	4.90	3.07
Female						
n = 12 (60%)						
M	51.00	47.00	98.00	28.00	16.00	18.00
SD	7.62	7.43	14.05	4.52	4.25	4.81
			Marital Status (N = 19)*			
Married						
n = 8 (40%)						
M	47.00	44.00	91.00	26.00	17.00	22.00
SD	9.77	6.81	16.36	4.28	4.65	2.87
Separated						
n = 1 (5%)						
M	43.00	35.00	78.00	25.00	17.00	12.00
SD	-	-	-	-	-	-
Divorced						
n = 2 (10%)						
M	57.00	52.00	108.00	18.00	18.00	20.00
SD	2.12	9.19	7.07	14.14	7.07	2.12
Widowed						
n = 1 (5%)						
M	47.00	42.00	89.00	22.00	19.00	21.00
SD	-	-	-	-	-	-
Single						
n = 7 (35%)						
M	52.00	47.00	99.00	28.00	16.00	18.00
SD	7.57	6.49	12.88	4.42	5.43	5.67

*One did not answer